

**New Jersey Department of Health and Senior Services  
Clinical Laboratory Improvement Services  
PO Box 361  
Trenton, NJ 08625-0361**

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**

Name of Blood Bank	County	Code Number
Address		
Name of Individual Completing Form	Telephone Number	

***Please furnish the following data for the report year and return to the above address. Please retain a copy for your files.***

***To cross-check your numbers, please balance your figures according to the following formula before submitting your data:***

$$\begin{array}{lcl}
 \textbf{Total Supply} & & \textbf{Total Returned} \\
 \text{[units on hand + units received]} & = & \text{+ Total Transfused} \\
 \text{+ units collected (if collecting)]} & & \text{+ Total Discarded}
 \end{array}$$

***If assistance is needed, contact the Clinical Laboratory Improvement Service at 609-292-0522.***

A. SOURCES OF SUPPLY	Whole Blood	Red Cells*	Totals
1. No. of units successfully drawn in your bank: a. Routine (Allogeneic )		////////	
b. Number of double red cell procedures performed by your bank in New Jersey (allogeneic) ( _____ x 2 = _____.)	////////		
c. Autologous		////////	
d. Directed		////////	
<b>2. Number of units on hand January 1 of report year.</b>			
3. Number of units (Total for Allogeneic, Autologous, Directed) supplied directly by:	////////	////////	////////
a. Bergen Community Regional Blood Center			
b. Blood Center of New Jersey			
c. Central Jersey Blood Center			
d. Community Blood Council of New Jersey			
e. Miller Memorial Blood Center			
f. New Brunswick Affiliated Hospital Blood Program			

\*Include frozen, washed and WBC-reduced red cells in this total (refer to Page 5, Section H, Number 5, 6 and 7).

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**  
Continued

Name of Blood Bank		Telephone Number	
<b>A. SOURCES OF SUPPLY, Continued</b>	<b>Whole Blood</b>	<b>Red Cells*</b>	<b>Totals</b>
g. American Red Cross: 1. Penn-Jersey, Philadelphia			
2. Other Red Cross			
h. New Jersey Blood Services/ New York Blood Center			
i. Out-of-State Community (Name and State) 1.			
2.			
j. Commercial Blood Banks (Name and State) 1.			
2.			
k. Blood Received Directly from AABB Exchange Programs (Actual units, not credits): 1. Volunteer Sources			
2. Commercial Sources			
l. Directly from other hospitals			
<b>TOTAL SUPPLY</b>			
<b>B. UNITS RETURNED (Only Unexpired Whole Blood or Red Cells for Allogeneic, Autologous and Directed Units)</b>			<b>Totals</b>
1. Community Blood Banks			
2. American Red Cross			
3. New Jersey Blood Services/New York Blood Center			
4. Commercial Suppliers			
5. Sent to Other Hospitals: a. Through the American Assoc. of Blood Banks (actual units, not credits)			
b. By directed transfer			
6. Balance on hand December 31 of the report year			
<b>TOTAL RETURNED</b>			

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**  
Continued

Name of Blood Bank					Telephone Number			
<b>C. USAGE (Whole Blood and Red Cells)</b>								
1. Number of crossmatches								
2. Number of patients transfused								
3. Number of units transfused (count split units as one)					<b>Whole Blood</b>	<b>Red Cells</b>	<b>Totals</b>	
a. Transfused as Allogeneic								
b. Transfused as Autologous								
c. Transfused as Directed								
<b>TOTAL TRANSFUSED</b>								
<b>D. DISCARDS</b>		<b>Allogeneic</b>		<b>Autologous</b>		<b>Directed</b>		<b>TOTALS</b>
		<b>Your Collec-tions</b>	<b>Other Sources</b>	<b>Your Collec-tions</b>	<b>Other Sources</b>	<b>Your Collec-tions</b>	<b>Other Sources</b>	
1. Number of Units (Red Cells and Whole Blood) discarded from:		/////	/////	/////	/////	/////	/////	/////
a. Outdating								
b. Reactive HBsAg								
c. Reactive HBcAb								
d. Reactive Test for HCV Antibody								
e. Reactive Test for HIV Antibody								
f. Reactive HTLV-1/HTLV-II								
g. Reactive Test for Syphilis								
h. Elevated ALT								
i. Irregular Antibodies								
j. Contamination, Breakage, etc.								
k. Donor Deferral Registry or Confidential Unit Exclusion								
l. Other-Specify (e.g., equipment failure):								
<b>TOTAL DISCARDED</b>								
2. Number of units in Question #1 above, confirmed positive for:								////////
a. HIV								
b. HB <sub>s</sub> Ag								
c. STS								
d. HCV								
<b>TOTAL</b>								

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**  
Continued

Name of Blood Bank		Telephone Number	
<b>E. NUMBER OF UNITS RECEIVED FROM SUPPLIERS (Do NOT include units collected at your facility)</b>	<b>Whole Blood</b>	<b>Red Cells</b>	<b>Total</b>
1. Allogeneic			
2. Autologous			
3. Directed			
<b>TOTAL</b>			
<b>F. NUMBER OF UNEXPIRED UNITS RETURNED TO SUPPLIERS:</b>	<i>////////</i>	<i>////////</i>	<i>////////</i>
1. Allogeneic			
2. Autologous			
3. Directed			
<b>TOTAL</b>			
<b>G. NUMBER OF TRANSFUSION REACTIONS:</b>			<i>////////</i>
1. Febrile			
2. Allergic			
3. Hemolytic (Cause)			<i>////////</i>
a. ABO (Specify):			
b. Clerical (Specify):			
c. Technical (Specify):			
d. Non-Specific			
e. Other (Specify):			
4. Anaphylactic			
5. Delayed			
a. Antibody(ies) causing the reaction:			<i>////////</i>
b. Number of days after transfusion:			<i>////////</i>
6. TRALI			
7. Bacterial Contamination			
<b>TOTAL</b>			

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**  
Continued

Name of Blood Bank						Telephone Number				
H. BLOOD COMPONENTS	Number of Units								No. of Patients Trans-fused	
	Prepared in Your Bank	Received From			Total	Total Trans-fused by Your Bank	Total Out-dated	Total Ret'd to Source Blood Center		
		Name	State	No.						
1. Fresh frozen plasma										
2. Single donor platelets-SDP										
3. Platelet concentrate										
4. Cryoprecipitates										
5. Frozen red cells**										
6. Washed red cells**										
7. Leukoreduced red cells**										
a. by filtration										
b. by centrifugation										
c. prestorage leukoreduced										
8. Leukocytes										
9. Stem Cells										
10. Other (Specify):										
**Please include in packed cells under A (Page 1) and C3 (Page 3).										
<b>I. APHERESIS (Collected in Your Facility)</b>						<b>Number of Donors</b>	<b>Number of Units</b>			
1. Plasmapheresis										
2. Leukapheresis										
3. Plateletpheresis										
If performed by another licensed blood bank, write name below:										

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**  
Continued

Name of Blood Bank		Telephone Number	
<b>J. THERAPEUTIC APHERESIS (Collected in Your Facility)</b>		<b>Number of Patients</b>	<b>Number of Procedures</b>
1. Plasma Exchange			
2. RBC Exchange			
3. Leukapheresis			
4. Plateletpheresis			
5. Stem Cell Harvesting			
If performed by another licensed blood bank, write name below:			
<b>K. SALVAGED PLASMA</b>			<b>Total</b>
1. Number of Units Salvaged:			////////
a. Total Units			
b. Total Liters			
<b>L. DISTRIBUTION OF SALVAGED MATERIAL</b>			
<b>Nature of Material</b>	<b>Volume (In Liters)</b>	<b>Name and Address of Destination</b>	
<b>M. PERIOPERATIVE AUTOLOGOUS BLOOD COLLECTION AND ADMINISTRATION</b>			<b>Total</b>
1. Number of intraoperative autologous procedures performed at your institution			
2. Number of postoperative autologous procedures performed at your institution			
3. Number of acute normovolemic hemodilution procedures performed at your institution			
4. Number of platelet rich plasma gel procedures performed at your institution			
<b>TOTAL</b>			
If performed by another licensed blood bank, write name below:			

**BLOOD BANK ANNUAL STATISTICS (HOSPITALS)**  
Continued

Name of Blood Bank		Telephone Number	
<b>N. LEAST INCOMPATIBLE TRANSFUSIONS</b>		<b>Number of Patients</b>	<b>Number of Units</b>
1. Total Number of Least Incompatible Transfusions			
<b>O. HOSPITAL STATISTICS</b>			<b>Total</b>
1. Total Number of Hospital Beds			
2. Total Number of Surgical Procedures			
<b>P. PERSONNEL</b>	<b>Supervisor</b>	<b>Technologist</b>	<b>Technician</b>
1. Total Number of Full Time Employees in Each Title			
2. Total Number of Part Time Employees (Prorated to full time: Total number of part time hours divided by 40 (round to nearest whole number).			
3. Total Number of Employees (1 + 2 = 3)			
<b>Q. CORD BLOOD COLLECTIONS</b>			<b>Total Number of Collections</b>
Name(s) of Licensed Cord Blood Banks that performs collections in your hospital			////////
1.			
2.			
3.			
<b>TOTAL</b>			

Name of Blood Bank Director (Print)	Telephone Number
Signature of Blood Bank Director	Date